



WELL CHILD EXAM - EARLY CHILDHOOD 2 YEARS

(Meets EPSDT Guidelines)

DATE

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| ໄວເດັກນັ້ນຕົ້ນ: 2 ປີ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ຊື່ເດັກ | ນຳເອົາມາໂດຍ | ວັນເກີດ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ອາການພຶດ | | ຢາທີ່ໃຊ້ຢູ່ໃນປະຈຸບັນ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ອາການເຈັບເປັນ/ອຸປະຕິເຫດ/ບັນຫາ/ສິ່ງກັງວົນ ນັບແຕ່ມາເທື່ອສຸດທ້າຍ | | ມີຂ້າພະເຈົ້າມີຄຳຖາມກ່ຽວກັບເຮືອງ: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| WEIGHT KG./OZ. PERCENTILE | HEIGHT CM/IN. PERCENTILE | HEAD CIR. PERCENTILE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Hearing | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adaptive/Cognitive | Language/Communication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gross Motor | Social/Emotional | Fine Motor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Behavior | <input type="checkbox"/> <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental Health | <input type="checkbox"/> <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| General appearance | N | A | Chest | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | Lungs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Head | <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular/Pulses | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eyes Cover/Uncover | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ears | <input type="checkbox"/> | <input type="checkbox"/> | Genitalia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nose | <input type="checkbox"/> | <input type="checkbox"/> | Spine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oropharynx/Teeth | <input type="checkbox"/> | <input type="checkbox"/> | Extremities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neck | <input type="checkbox"/> | <input type="checkbox"/> | Neurologic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nodes | <input type="checkbox"/> | <input type="checkbox"/> | Gait | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NEXT VISIT: 3 YEARS OF AGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HEALTH PROVIDER SIGNATURE | | HEALTH PROVIDER ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

SEE DICTATION

Guidance to Physicians and Nurse Practitioners for Early Childhood (2 years)

The following highlight EPSDT screens where practitioners often have questions. They are not comprehensive guidelines.

Fluoride Screen

Fluoride supplements should be considered for all children drinking fluoride deficient (<0.6 ppm F) water. Before supplements are prescribed, it is essential to know the fluoride concentration of the patient's drinking water. Once the fluoride level of the water supply has been evaluated, either through contacting the public health officials or water analysis, as well as evaluating other sources of fluoride, the daily dosage schedule can be recommended. Pediatric Dentistry: Reference Manual 1999--00.(21)5.

Lead Screen

Screen children for these risk factors:

- Live in or frequently visits day care center, preschool, baby sitter's home or other structure built before 1950 that is dilapidated or being renovated.
- Come in contact with other children with known lead toxicity (i.e., blood lead 15 ug/dl).
- Live near a lead processing plant or with parents or household members who work in a lead-related occupation (e.g., battery recycling plant).

Pneumococcal Screen

Screen children for these risk factors:

- Age 2 and over with chronic illnesses specifically associated with pneumococcal disease or its complications; anatomic or functional aspenia; sickle cell disease; nephritic syndrome or chronic renal failure; cerebrospinal fluid leaks; or conditions associated with immunosuppression.

Hepatitis B Vaccine

- For children and adolescents not vaccinated against hepatitis B in infancy, begin the hepatitis B vaccine series during any childhood visit. Give the second dose at least one month after the first dose and give the third dose at least four months after the first dose and at least two months after the second dose.

Developmental Milestones

Always ask about and follow-up on parent concerns about development or behavior. You may use the following screening list, or use the Ages and Stages Questionnaire, the Denver II, the ELMS2 (a language screen), or the MacArthur Communication Development Inventory.

Yes No

- | | | |
|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Kicks ball forward.</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Removes article of clothing (not hat).</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Combines 2 words.</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses own name to refer to self. |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Vocabulary of more than 50 words.</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Strangers understand half child's speech. |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Understands a two-step verbal command ("Pick up the toy; put it away") without gestures.</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Points to 6 named body parts (nose, eyes, ears, mouth, hands, feet, tummy, hair). |
| <input type="checkbox"/> | <input type="checkbox"/> | Stacks 4 blocks. |

- Persistent rocking, hand flapping, head banging, or toe walking.
- No spontaneous two word (not echolalic) phrases.
- Any loss of any language or social skills.

Instructions for developmental milestones: At least 90% of children should achieve the underlined milestones by this age. If you have checked "no" on **any two items**, *even one* of the underlined items, or any of the **boxed items** (abnormal behavior at this age), refer the child for a formal developmental assessment.

Notes: Immunization schedules are from the Advisory Committee on Immunization Practice of the U.S. Centers for Disease Control and Prevention. **Parents and providers may call Healthy Mothers, Healthy Babies (1-800-322-2588) with questions or concerns on childhood development.**

ສຸຂພາບເດັກຂອງທ່ານເມື່ອໄດ້ 2 ປີ

ປາກົດການຊີວິດ

ວິທີການເຕີບໂຕຂອງເດັກນ້ອຍຂອງທ່ານ
ລະຫວ່າງອາຍຸ 2 ປີ ຫາ 3 ປີ.

ເຕັ້ນຢູ່ບ່ອນເກົ່າ.

ຖີບຣິດຖີບສາມລໍ້.

ເວົ້າປໂຍກສາມ ຫລື ສີ່ຄໍາ.

ກິນ ແລະ ນຸ່ງເຄື່ອງລາວ (ຊາຍ) ເອງ.

ສາມາດແຕ້ມຂ່ວຍຕົນກາ ແລະ ວົງມົນດ້ວຍສີ່ສີ.

ຫລິ້ນເກມ "ສົມມຸດ" ກັບຕຸກກະຕາ ແລະ ສັດຜ້າຍັດ.

ທ່ານຊ່ວຍເດັກຂອງທ່ານຮຽນວິຊາໃໝ່
ໂດຍການຫລິ້ນກັບລາວ (ຍິງ).

ການຊ່ວຍເຫລືອ ຫລື ອໍ້ມູນເພີ່ມເຕີມ.

ອໍ້ມູນການມັດຮຽນປີນແບບປອດໄພ:
1-800-LOK-IT-UP (565-4887)

ຄໍາຖາມການລ້ຽງເດັກ: ການພົວພັນການສິ່ງຕໍ່ໄປ ແລະ
ແຫລ່ງການລ້ຽງເດັກ ຮັດວໍຊິງຕັນ, 1-800-446-1114.

ການປ້ອງກັນຂອງເປື້ອນ: ສູນກາງປ້ອງກັນຂອງເປື້ອນ
ຮັດວໍຊິງຕັນ 1-800-732-6985 ຫລື 1-800-572-0638
(ສາຍຄົນເສຍອົງຄະ TTY).

ສໍາລັບການຊ່ວຍເຫລືອ ຖ້າທ່ານຮູ້ສຶກກະວົນກະວາຍ
ກັບເດັກຂອງທ່ານຫລາຍ: ສາຍຊ່ວຍຄອບຄົວ,
1-800-932-HOPE (4673) ສາຍສຸກເສີນຕາມທ້ອງຖິ່ນ.

ຄວາມຮູ້ການເປັນພໍ່ແມ່ ຫລື ການສນັບສນູມ: ສາຍຊ່ວຍ
ເຫລືອຄອບຄົວ, 1-800-932-HOPE (4673) ແຫລ່ງຕ່າງໆ
ດ້ານຄອບຄົວເຂດ ນໍແວສ໌ 1-888-746-9568 ຫ້ອງຮຽນ
ຕາມວິທະຍາໄລທ້ອງຖິ່ນ.

ຄໍາແນະນໍາດ້ານສຸຂພາບ

ການສັກຢາກັນຂອງເດັກຂອງທ່ານຖືກກັບເວລາບໍ່? ຖ້າຖືກ, ລາວ (ຊາຍ)
ຈະບໍ່ຕ້ອງການອີກຈົນຮອດກ່ອນເວລາລາວ (ຊາຍ) ເວົ້າອະນຸບານ.

ເອົາອາຫານທີ່ດີຕໍ່ສຸຂພາບຫລາຍໆຊະນິດໃຫ້ເດັກຂອງທ່ານທຸກມື້. ຈໍາກັດ
ອາຫານທີ່ບໍ່ມີຄຸນຄ່າ. ກິນອາຫານຮ່ວມກັນຖານເປັນຄອບຄົວໃຫ້ເລື້ອຍເທົ່າທີ່
ຈະເລື້ອຍໄດ້. ເວລາກິນນໍາກັນໃຫ້ມອດທີວີໄວ້.

ຜັດແຂ້ວເດັກຂອງທ່ານຢ່າງນ້ອຍນຶ່ງເທື່ອຕໍ່ມື້ ດ້ວຍຢາສູນມີສາມ ຟຣູໂຣດ໌
ຈໍານວນຂະນາດຖົ່ວແຮ. ໃຫ້ແນ່ໃຈວ່າລາວ (ຍິງ) ໄດ້ກວດແຂ້ວນຶ່ງເທື່ອຕໍ່ປີ.

ຄໍາແນະນໍາການເປັນພໍ່ແມ່

ເວົ້າກັບເດັກຂອງທ່ານກ່ຽວກັບສິ່ງລາວ (ຊາຍ) ເຮັດ. ອ່ານປຶ້ມຮູບນໍາກັນ
ແລະ ເວົ້າກ່ຽວກັບຮູບ.

ຊ່ວຍເດັກຂອງທ່ານມ່ວນຊື່ນກັບເກມເຄື່ອນໄຫວ ເຊັ່ນວ່າ ຈັບ, ຕໍ່ຮາງ,
ແລະ ເຊື້ອນ- ແລະ - ຊອກ. ເອົາເຄື່ອງຫຼິ້ນງ່າຍໃຫ້ລາວ (ຍິງ) ເພື່ອ
ຫລິ້ນ, ເຊັ່ນວ່າ ບລອກ, ສີ່ສີ ແລະ ເຈ້ຽ, ສັດຜ້າຍັດ.

ທ່ານອາດຢາກໃຫ້ເດັກຂອງທ່ານໄດ້ແບບໃຊ້ຫ້ອງນໍາໃນໄວໆນີ້, ແຕ່ລາວ
(ຊາຍ) ອາດຍັງບໍ່ພ້ອມຈົນກວ່າອາຍຸຈະຮອດປະມານ 3 ປີ. ລາວ (ຊາຍ)
ສະແດງໃຫ້ທ່ານຮູ້ວ່າລາວພ້ອມແລ້ວໂດຍບໍ່ປຽກຫລັງຈາກນອນ ແລະ
ບອກທ່ານເວລາລາວ (ຊາຍ) ຢາກຖ່າຍ.

ຈໍາກັດໂທຣະທັດເປັນ 1 ຊົ່ວໂມງ ຫລື ນ້ອຍກວ່າສໍາລັບເດັກ. ເບິ່ງນໍາເວົ້າ
ເຈົ້າ ແລະ ເວົ້າກ່ຽວກັບຮາຍການ.

ຄໍາແນະນໍາດ້ານຄວາມປອດໄພ

- ມັດຮຽນອຸປະກອນເຮັດຄວາມສະອາດ ແລະ ຢາໄວ້ບ່ອນເດັກເອົາບໍ່ເຖິງ.
- ໃຫ້ຈັບມືຂອງເດັກຂອງທ່ານຕອດເວລາຍ່າງໃກ້ການສັນຈອນ, ລວມ
ທັງບ່ອນຈອດຮົດ. ກ່ອນຖອຍຮົດໃຫ້ກວດເບິ່ງດ້ານຫລັງຮົດຂອງທ່ານ
ກ່ອນ ໃນກໍຣະນີອາດມີເດັກອາດຢູ່ທາງກົນຮົດ.
- ຖ້າທ່ານມີປີນຢູ່ເຮືອນ, ຈົ່ງມັດຮຽນມັນໄວ້ຢ່າງປອດໄພຕອດ. ຮັກສາມັນໄວ້
ໂດຍບໍ່ມີລູກ ແລະ ລອກໄວ້.
- ນຸ່ງເສື້ອຊຸຂີບໃຫ້ເດັກຂອງທ່ານທຸກເວລາທີ່ລາວ (ຍິງ) ຢູ່ໃກ້ນໍ້າ ຫລື
ຢູ່ນໍ້າເຮືອ. ຈົ່ງເບິ່ງລາວ (ຍິງ) ຕອດເວລາຢູ່ນໍ້ານໍ້າ.
- ມັດຮຽນກັບຂີດໄຟ ແລະ ກັບໄຟໄວ້ບ່ອນເດັກເອົາບໍ່ໄດ້.